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Department of Veterans Affairs **VHA DIRECTIVE 2002-036**
Veterans Health Administration
Washington, DC 20420 **June 21, 2002**

GUIDANCE ON VA'S ROLE IN TRICARE FOR LIFE

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes policy for Department of Veterans Affairs (VA) medical facilities delivering care to Department of Defense (DOD) beneficiaries who seek to utilize VA medical facilities for medical treatment under DOD's TRICARE for Life (TFL) Program.

2. BACKGROUND

a. Public Law 106-398, the Fiscal Year 2001 National Defense Authorization Act, expanded TRICARE benefits to cover all military retirees, spouses and survivors aged 65 and older who are eligible for Medicare Part A (for hospitalization payments) and enrolled in Medicare Part B (for other provider payments). TFL was implemented October 1, 2001.

b. TFL eligible DOD beneficiaries using private sector medical facilities will receive all Medicare-covered benefits under Medicare Standard plus all TRICARE covered benefits. Beneficiaries will self-refer to providers of their choice. For most beneficiaries who use a Medicare provider, Medicare will be first payer for all Medicare-covered services and TRICARE will cover the remainder of the beneficiary's out-of-pocket costs if the service is also a TRICARE benefit. TRICARE will cost-share with TFL beneficiaries and function as first payer for services and/or benefits covered by TRICARE, but not Medicare. If the beneficiary has other health insurance (OHI), TRICARE becomes the third payer after Medicare and OHI.

c. DOD has a separate policy for payment for TFL services provided by VA medical facilities since Medicare is not authorized to pay VA. TFL-eligible DOD beneficiaries using VA medical facilities will receive all TRICARE covered benefits. Beneficiaries choosing to utilize TFL benefits through VA providers will self-refer. TRICARE will function as first payer for services and benefits covered by TRICARE; however, VA services provided through TFL will be subject to cost-sharing requirements, such as annual deductibles and copayments. TFL beneficiary out-of-pocket cost shares may not be waived for services provided by VA under the TFL program. If the beneficiary has OHI, TRICARE becomes the second payer after OHI. Medicare is not authorized to pay VA for any services provided to Medicare-eligible patients, including those covered by TFL.

d. Subject to Title 38 United States Code, Chapter 17, VA is responsible for providing needed medical care to enrolled veterans regardless of whether the veterans have dual VA and DOD eligibility. If the veteran has OHI coverage, it may cover VA copayments.

e. VA health care facilities with TRICARE contracts (participating in TRICARE managed care networks) may be TFL providers . TRICARE managed care networks consist of providers who agree to provide services to TRICARE beneficiaries at rates established with TRICARE managed care support contractors. TRICARE network discounts shall only be applied when the

discount arrangement specifically includes the TFL population. TRICARE will reimburse these facilities at TRICARE Extra rates. Non-network VA facilities also may be TFL providers provided they obtain an authorization statement from a TRICARE managed care support contractor. TRICARE will reimburse non-network facilities at TRICARE Standard rates. ***NOTE:*** *Payment guidance for VA facilities is stated in DOD 's Managed Care Support Operations Manual 6010.49-M, Chapter 9, Section 4, "Double Coverage," paragraph 1. 3.4; paragraph 1.3.6; and paragraph 4.0.*

f. TFL beneficiaries, including non-veterans, are eligible for services at VA health care facilities. The amount of the required cost-share payment assessed to the DOD TFL beneficiary will depend on the status of the VA facility as a TRICARE network or non-network health care provider. TFL beneficiaries are subject to all applicable TFL cost-sharing requirements. TFL and VA patient cost-sharing amounts are subject to change.

g. TFL beneficiaries, including dually-eligible veterans, requesting to be seen as TFL beneficiaries will be honored upon verification of their enrollment in TRICARE. The facility must bill OHI, if applicable, before billing TRICARE for covered services.

h. VA will be responsible for collecting all TRICARE Extra or Standard copayments and deductibles. If the VA medical center is a network provider, the medical center would apply TRICARE Extra cost shares. If the VA medical center is not a network provider, the medical center would apply TRICARE Standard cost shares.

i. TRICARE beneficiaries may be seen, provided services are in areas where excess capacity has been determined. Veterans always have priority to care.

3. POLICY: It is VHA policy that medical facilities provide information on current cost-sharing requirements for DOD beneficiaries considering utilizing TFL benefits at VA only at the time the potential TFL beneficiary first presents for care. ***NOTE****: This information is to include cost-sharing information for: (1) TFL services provided by the Private Sector, (2) TFL services that would be provided by VA facilities; and (3) a veteran who is seen as a veteran by VA (see Att. A).*

4. ACTIONS: Facility Directors are responsible for ensuring that:

a. DOD beneficiaries considering utilizing TFL benefits at VA are provided information on current cost-sharing requirements only at the time the potential TFL beneficiary first presents for care.

b. If a TFL beneficiary selects care through VA, the beneficiary is billed for the TFL patient cost share.

c. OHI is billed, if applicable, before billing TRICARE for the care provided.

d. If not a TRICARE network provider, an authorization statement is obtained from the TRICARE contractor in their region to treat TFL beneficiaries under the terms of TRICARE

Standard. ***NOTE:*** *It is the responsibility of the facility to be informed concerning the scope of TRICARE Standard benefits.*

5. REFERENCES

a. DOD 's Managed Care Support Operations Manual 6010.49-M, Chapter 9, Section 4, "Double Coverage" (Paragraph 1. 3.4; Paragraph 1.3.6; and Paragraph 4.0). This manual may be found at www.tricare.osd.mil//ebc/rm/test_09.html.

b. For current TFL information consult: TRICARE Management Activity at www.tricare.osd.mil. Cost-sharing information can be found at: http://www.tricare.osd.mil/tfl/matrix.html.

6. FOLLOW-UP RESPONSIBILITY: The Medical Sharing Office (176) is responsible for the content of this Directive. Questions may be referred to 202-273-8411.

7. RECISSION: None. This Directive expires June 30, 2007.

S/ Frances M. Murphy, M.D., M.P.H. for
Robert H. Roswell, M.D.
Under Secretary for Health

Attachment

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ATTACHMENT A

Comparison of Out of Pocket Expenses borne by TRICARE for Life (TFL) Beneficiary				
Type of Service	**Seen in Department of Veterans Affairs (VA) as a Veteran**	**Seen as a TFL Beneficiary at a VA Facility that is a Network Provider TRICARE Extra**	**Seen as a TFL Beneficiary at a VA Facility that is not a Network Provider TRICARE Standard**	**Seen as a TFL Beneficiary at a Private Sector Provider***
Deductible	No general deductible.	$150 per individual or $300 per family per year.	$150 per individual or $300 per family per year.	Medicare deductible paid by TRICARE.
Pharmacy	Medication copayments may be assessed to veterans enrolled in Priority Groups 2-6 when the medication is dispensed on an outpatient basis for the treatment of a nonservice-connected condition. The copayment is $7 for Priority Group 7. The copayment is charged for each 30 days or less supply of medication.	TRICARE network pharmacies: $3.00 for up to a 30-day supply of a generic prescription drug and $9.00 for up to a 30-day supply of a name brand prescription drug. Limited availability.	VA pharmacies are not able to provide non-network benefits.	TRICARE network pharmacies: $3.00 for up to a 30-day supply of a generic prescription drug and $9.00 for up to a 30-day supply of a name brand prescription drug. Non-network pharmacies: 20 percent cost-share or $9.00, whichever is greater, after meeting the TRICARE annual deductible.
Outpatient	The outpatient copayment is based upon the level of care provided. Preventive medicine and other services (lab, x-ray, EKG) will have no copayment.** For primary care outpatient visits, veterans who are required to pay a means test copayment will be charged $15. Specialty care outpatient visits will have a $50 copayment.	20 percent of contracted fee.	25 percent of the allowable charge.	None for Medicare and TRICARE covered services.

*For more specifics refer to http://www.tricare.osd.mil/tfl/default.html.

** Publicly announced VA public health initiatives (e.g., health fairs) or an outpatient visit solely consisting of preventive screening and/or immunizations (e.g., influenza immunization, pneumonococcal immunization, hypertension screening, hepatitis C screening, tobacco screening, alcohol screening, hyperlipidemia screening, breast cancer screening, cervical cancer screening, screening for colorectal cancer by fecal occult blood testing, and education about the risks and benefits of prostate cancer screening) are exempt from copayments.

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Inpatient	The current Medicare deductible rate is $812, plus $10 for each day for veterans who are required to pay a means test copayment.	$250 per diem copayment or 25 percent cost-share of total charges based on contracted fee, whichever is less. Plus, 20 percent cost-share, based on contracted fee, of separately billed professional charges.	$250 per diem copayment or 25 percent cost-share of billed charges for institutional services, whichever is less. Plus, 25 percent cost-share of allowable charges for separately billed professional charges.	Days 1-150 – None for Medicare and TRICARE covered services. Days 151+ 20 percent of allowable charges if care is delivered in a TRICARE network hospital or 25 percent of allowable charges if care is delivered in a Non-network hospital.

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